Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: PINECREEK MEDICAL CENTER 9032 HARRY HINES BLVD DALLAS TX 75235	MFDR Tracking #: M4-07-0918
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Box #: PACCAR INC Box #:19	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Prior authorization was given & the surgeon for this procedure has been paid."

Amount in Dispute: $11,288.57

PART III: RESPONDENT'S POSITION SUMMARY

Carrier did not respond to the DWC-60 packet.

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
10/14/05	111, 250, 270, 272, 278, 300, 360, 370, 424 and 710	N/A	$11,288.57	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code Section 413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.305 relates to MDR – General.
2. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
3. 28 Tex. Admin. Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Tex. Admin. Code §133.305 and 133.307?
2. Is the requestor eligible for medical fee dispute resolution under 28 Tex. Admin. Code §133.307?

Findings

1. The requestor filed a dispute with the Medical Fee Dispute Resolution section at the Division. According to 28 Tex. Admin. Code §133.305(a)(4), a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Tex. Admin. Code §133.305(b) goes on to state, "Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in

accordance with Labor Code §413.031 and 408.021". The dispute is resolved by the Division of Workers' Compensation pursuant to 28 Tex. Admin. Code §133.307. 28 Tex. Admin. Code §133.307(e)(3)(H) requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to §124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals. The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires filing for a Benefit Review Conference pursuant to 28 Tex. Admin. Code §141.1. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved as of the undersigned date.

2. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Tex. Admin. Code §133.307.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

		2/2/11
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
		2/2/11
Authorized Signature	Medical Fee Dispute Resolution, Manager	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.